l l		(X2) MULTIPLE CONSTRUCTION (X3) DATE S			SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMI		COMPL	ETED	
		155206	B. WING			06/24/2	011
			1	STREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	8			DRNADAY ROAD		
BROWN!	SBURG HEALTH C	ARE CENTER			ISBURG, IN46112		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		- 1	CROSS-REFERENCED TO THE APPROPRIAT	E	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0000							
	This visit was for the investigation of complaint IN00091302. Complaint number IN00091302: Substantiated, Federal/State deficiencies related to the allegations are cited at F279 and F323 Survey dates: June 23 and 24, 2011 Facility number: 000113 Provider number: 155206 This visit was for the Investigation of complaint IN00091302. AIM number: 100287670 Survey team: Vanda Phelps, R.N. Census bed type: 3 SNF 126 SNE/NE		F000	PREFIX (EACH CORRECTIVE ACTION SHOULD		n by nter d in e or ons	
	126 SNF/NF						
	129 Total						
	Census payor typ 21 Medicare 87 Medicaid 21 Other 129 Total Sample: 5						
	These deficienci	es also reflect state					
LABORATOR	Y DIRECTOR'S OR PROV	/IDER/SUPPLIER REPRESENTATIVE'S SIG	NATURE		TITLE		(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6FKC11

Facility ID:

000113

		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	INSTRUCTION 00	(X3) DATE SURVEY COMPLETED
155206		A. BUILDING B. WING		06/24/2011	
	PROVIDER OR SUPPLIER SBURG HEALTH CA		1010 H	ADDRESS, CITY, STATE, ZIP CODE ORNADAY ROAD NSBURG, IN46112	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
	16.2. Quality review comp	•			
F0279 SS=D	assessment to deveresident's comprese The facility must descare plan for each measurable object a resident's medic psychosocial needs comprehensive as The care plan must are to be furnished resident's highest mental, and psychological under §48 would otherwise be but are not provide exercise of rights or right to refuse treat Based on recordate the facility failed which accurately aides to deliver a residents reviewed survey sample of causing Resident	Quality review completed 6/27/11 Cathy Emswiller RN A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to develop a plan of care which accurately guided certified nurse aides to deliver appropriate care to 1 of 5 residents reviewed for plans of care in the survey sample of 5. This contributed to causing Resident G to experience two fractures during a transfer. (Resident G)		What corrective actions will be accomplished for those reside found to be affected by the deficient practice? It is the poof the facility that every reside has a care plan which accuraguides the care of the reside that is accessible by both nurand C.N.A.'s. Resident G is a year old resident who sustain left mid clavicular fracture and left humeral neck fracture. Howas in the stand up lift and be cleaned when he stated he	dents blicy dent ately ent rses a 68 ned a nd a e

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6FKC11

Facility ID: 000113

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY			
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00		00	COMPLETED		
		155206	1			06/24/2	011
			B. WIN		ADDRESS, CITY, STATE, ZIP CODE	ļ	
NAME OF	PROVIDER OR SUPPLIE	R					
DDOM/NI	CDUDO LIEALTU O	ADE CENTED		1	ORNADAY ROAD		
BROWN	SBURG HEALTH C	ARE CENTER		BROW	NSBURG, IN46112		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE	COMPLETION
TAG	REGULATORY OF	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	On 6/23/11, duri	ing the orientation tour at			couldn't be up any longer. H		
	10:30 a.m., Uni	t Manager #2 indicated			knees buckled and he sat in		
	Resident G had	fractured his			sling. When moved to a cha		
	clavicle/collarbo	one while being			complained of left arm and of pain and was evaluated and		
		of bed with a stand-up lift.			to ER. The hospital x-ray rep		
	l dansieried out o	or oca with a stand-up lift.			showed no signs of traumati		
					fracture and noted bones we		
		lent G's clinical record			osteopenic. Resident did no		
	was completed of	on 6/24/11 at 12:05 p.m.			complain of any pain until w	as	
	His diagnoses in	cluded, but were not			placed in the chair.The only		
	limited to, histo	ry of stroke, hemiplegia,			resident affected by the prac	ctice	
		l osteoarthritis. He had			is resident G. All residents		
	_	d 5/29 to 6/1/11 for repair		requiring assistance with transfers will be assessed by the		. 41	
	1	•				•	
		avicle and humerus (upper			DON and Therapy Director f ability to use the stand-up lif		
	· '	11 five-day Resident			care plans and aide assignn		
	Assessment Inst	rument indicated he was			sheets will be updated to ref		
	completely alert	and oriented and his			any changes in tranfer		
	speech was clear	r. It indicated he was			techniques. Residents who		
	1 ^	aff for all care except			require assistance with trans	sfers	
	1 ^	ransferred only twice			will be reviewed in the week		
	_	-			SWAT meeting with the DON		
	1	assessment period. To			Therapy Director in attendar	nce	
	· ·	ent G's weight was 284			and the care plan and aide		
	pounds.				assignment sheets will be updated to reflect any chang	100	
					Evaluations are ongoing and		
	During interview	w with Resident G on			also be done on new admiss		
		on, he said, "Two aides			who require assist with trans		
	1	traption and I couldn't			by the Therapy Director and		
		telling them, but they just			DON. C.N.A.'s #1 & #2 as w	ell as	
	_				the Unit Manager have rece		
		o hold on. Well, I			disciplinary action and inser		
	couldn'tit was hurting too much and I'm not so strong anymore. I leaned toward				in regards to the transfer and		
					of the lift. His current care pl		
	the chair and tha	it's when the bad pain			and aide assignment sheet sto use the hoyer lift. Aides ar		
		so stated, "I haven't been			to access the care plans in t		
		on my legs for a long			charts with the nurses when		
	timesince the s				they want to look at them.Ho		
	I minesince the s	nioke.					

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	(X2) MULTIPLE CONSTRUCTION A. BUILDING 00			(X3) DATE SURVEY	
		A. BUI				COMPLETED 06/24/2011	
		B. WIN			06/24/2	011	
NAME OF	PROVIDER OR SUPPLIEF	R		1	DDRESS, CITY, STATE, ZIP CODE		
DDOWN.	SBURG HEALTH C	ADE CENTED		1	ORNADAY ROAD NSBURG, IN46112		
_		-		L .	NSBURG, IN40112		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	ICY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION DATE
IAU	REGULATORT OR	LISC IDENTIFTING INFORMATION)	+	IAU	other residents affected by the	10	DATE
	Index in Com	.: C . 1 N			same deficient practice be	ic .	
		tified Nurse Aide #1 on			identified and what corrective	9	
	_	o.m. indicated she			actions will be taken?All residual		
		ent G's call light to find he			requiring assistance with tran		
		ead of his bed to a 90			have the potential to be affect by the practice. Staff inservio		
	"	l it had stuck there. But,			on the stand-up lift and trans	-	
		ntary stool, he needed			was done on 6/2/11 and is	. 3. 3	
		e immediately and it			on-going. The stand-up lift is		
		omplished in his bed as			to be utilized with a resident		
	usual. She said	she and another CNA			the Therapy Director and DC have assessed the resident		
	"thought and tho	ught" about it and			approved its use. Residents		
	decided to lift hi	m in the stand-up lift and			require assistance with trans		
	wash him while	he was there. She			will be reveiwed weekly in the		
	indicated she and	d CNA #2 had not			facility SWAT meeting with the		
	conferred with the	ne charge nurse before		Therapy Director and DON in attendance. Care plans and aide			
		sion. She indicated they					
	1	nd-up lift before for			at		
		d done OK. She also			measures will be put into pla		
	indicated the CN				and what systemic changes		
		mation sheets at that time			be made to ensure the defici practice does not recur? Staf		
	1 ~	at he could not bear			inservicing was done on 6/2/		
		e the stand-up lift for			and is ongoing on the use of		
	1	#1 indicated Resident G			stand-up lift and transfers.		
		d telling them he couldn't			Transfers will be reviewed w		
	_	e. She indicated they			in the facility SWAT meeting the Therapy Director and DC		
		-			present.Care plans and aide		
	knew he could do it because he'd done it before. He used his arms and shoulders to				assignment sheets will be		
		She indicated all at			updated with any changes.H	ow	
	_	Idn't hold on and let			will the corrective actions be monitored to ensure the defice	niont	
					practice does not recur, ie, w		
	_	lownwards and started			quality assurance program w		
	screaming to sen	d him to the hospital.			put into place and the comple	etion	
	D	0.1 7/0.4/11 (23.14			date?The Therapy Director a		
		y of the 5/24/11 CNA			DON will review all transfers		
	assignment/infor	mation list, which was in			the weekly facility SWAT med	zung	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	A. BUILDING 00		COMPLETED	
155206		B. WING 06/24/2011				011	
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF	PROVIDER OR SUPPLIEF	ę.		1010 H	ORNADAY ROAD		
	SBURG HEALTH C				NSBURG, IN46112		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	` `	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	+	TAG	and also on all new admission		DATE
		, indicated "does not bear			Care plans and aide assignn		
	weightUses sta	and up lift for transfers"			sheets will be updated with		
					changes. Any continued con	cerns	
	1	arrent care plan indicated			will be addressed in the mon	•	
	it addressed the	issue of fall risk. The			Quality Assurance meeting v		
	entry was dated	as initiated on 7/27/2010			written action plan. The plan be monitored by the	WIII	
	and was printed	with hand written			Administrator/DON/designee	until	
	interventions add	ded. One of the hand			resolution occurs.Currently the		
	written intervent	ions was dated 11/19/11:			are no residents utilizing the		
	"hoyer lift transf	er-use 2 people."			stand up lift in the facility.		
	Interview with the	ne Director of Nursing					
		o.m. indicated she was					
	aware the nurse						
		rmation sheet which was					
	1 ~	/11 did indicate both					
		ation: Resident G could					
	1 ^	and to use the stand-up					
	1	She agreed this was					
	1	_					
	1	d had become aware of it					
	1 -	vent occurred. She had					
	1 ^	now unacceptable this					
	1 '	rept repeating" to her that					
		he did it beforehe just					
		Review of the current					
	1	nment/information sheet					
		ndicated it did state he					
	could not bear weight, but it did not direct						
		o transfer him. CNAs					
	were not allowed	d to review the charts					
	where the full ca	re plan was maintained.					
	This federal tag	relates to complaint					
	number IN0009	1302.					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA X2) MULTIPLE CONSTRUCTION X3) DATE SURVEY AND PLAN OF CORRECTION IDENTIFICATION NUMBER: COMPLETED 00 A. BUILDING 155206 06/24/2011 B. WING STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1010 HORNADAY ROAD BROWNSBURG HEALTH CARE CENTER BROWNSBURG, IN46112 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (X5) PROVIDER'S PLAN OF CORRECTION PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY) PREFIX (EACH DEFICIENCY MUST BE PERCEDED BY FULL PREFIX COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG DATE 3.1-35(d)(1)3.1-35(d)(2)The facility must ensure that the resident F0323 environment remains as free of accident SS=G hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. What corrective actions will be Based on observation, record review and F0323 06/27/2011 accomplished for the residents interview, the facility failed to ensure the found to be affected by the safety of 1 of 5 residents reviewed for deficient practice? It is the policy accidents in the sample of 5 in that, of the facility to ensure the safety of residents at all times. Resident although he was assessed as unable to G is a 68 year old resident who bear weight, he was transferred via a sustained a left mid clavicular stand-up lift per instructions on the nurse fracture and a left humeral neck aide information sheet which were in fracture. He was in the stand-up conflict with the official care plan of lift and being cleaned up when he stated he couldn't stand any record. This resulted in fractures of his longer. His knees buckled and he upper arm and collarbone. (Resident G) sat in the sling. He was then moved to a chair where he complained of left arm and chest Findings include: pain. He was evaluated and sent to the ER. Resident did not During the orientation tour of 6/23/11 at complain of any pain until he was 10:30 a.m., Unit Manager #2 indicated placed in the chair. The hospital Resident G had fractured his x-ray showed no signs of traumatic fracture and noted that clavicle/collarbone while being the bones were osteopenic. The transferred out of bed with a stand-up lift. only resident affected by the She indicated he also had left hemiplegia practice is resident G. All and was full care. She indicated he was residents (including new admissions) requiring assistance interviewable but it would be extremely with transfer will be assessed by difficult because he spoke a Slavic the Therapy Director and DON for language.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

6FKC11

Facility ID:

000113

If continuation sheet

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I 155206			ULTIPLE CO LDING	NSTRUCTION 00	(X3) DATE :	ETED	
		B. WIN	IG		06/24/2	011	
	PROVIDER OR SUPPLIES		•	1010 H	DDRESS, CITY, STATE, ZIP CODE DRNADAY ROAD	•	
BROWN	SBURG HEALTH C	ARE CENTER		BROWN	NSBURG, IN46112		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	ГЕ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
TAG	Review of Residuals was completed of His diagnoses in limited to, histo osteoporosis and 6/8/11 five-day Instrument indicalert and oriented clear. It indicats staff for all care transferred only assessment period Resident G's weith The nursing noted 4:15 p.m. indications. It (left) pain.' (sic)" The notified and respectively and respectively assessment of the emergency he was subsequed fractures of his complete the couldn'tit was been subsequed to the emergency he was subsequed fractures of his complete the couldn'tit was been subsequed to the emergency he was subsequed fractures of his complete the couldn'tit was been subsequed to the emergency he was subsequed fractures of his complete the couldn'tit was been subsequed to the emergency he was subsequed fractures of his complete the couldn'tit was been subsequed to	dent G's clinical record on 6/24/11 at 12:05 p.m. cluded, but were not rry of stroke, hemiplegia, losteoarthritis. His resident Assessment ated he was completely d and his speech was ed he was dependent on except eating and had twice within the 7-day od. To be noted, light was 284 pounds.		TAG	ability to use the stand-up lift care plans and aide assignmes sheets will be updated with changes. Residents requiring assistance with transfers will evaluated in the facility week SWAT meeting with the Ther Director and DON in attenda Assignment sheets and care plans will be updated with changes. C.N.A.'s #1 & #2 as the unit manager have received disciplinary action a inservicing in regards to transand the use of the stand-up lift sheet will be assignment sheet state use a hoyer lift for transfer. Currently there are no reside utilizing the stand up lift in the facility. How will other residen affected by the same practice identified and what corrective actions will be taken? All residentified and what corrective actions will be taken? All residentified and inservice on the stand-up lift and transwa done on 6/2/11 and is ongoing. The stand-up lift is be utilized with a resident un Therapy Director and DON hassessed the resident and approved its use. Residents require assistance with transwill be reviewed in the facility weekly SWAT meeting with the Therapy Director and DON in attendance. The care plans a aide assignment sheets will updated with any changes. Well applied to the stand-up care plans a aide assignment sheets will updated with any changes. Well applied to the stand-up care plans a aide assignment sheets will updated with any changes. Well applied to the stand-up care plans a aide assignment sheets will updated with any changes. Well applied to the stand-up changes. Well applied to the stand-up care plans a aide assignment sheets will updated with any changes. Well applied to the stand-up lift and transactions and the stand-up lift and transactions and the stand-	ent be be ly appy nce. s well and sfers ift. an to ents e be dents sfer title ting fers not to till the ent and be and be and be	DAIE
		t's when the bad pain			measures will be put into pla		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		NSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A BIII	LDING	00	COMPL	ETED	
		155206	B. WIN			06/24/2	011
		<u>I</u>			ADDRESS, CITY, STATE, ZIP CODE		
NAME OF 1	PROVIDER OR SUPPLIEI	₹		1	ORNADAY ROAD		
	SBURG HEALTH C	ARE CENTER		1	NSBURG, IN46112		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION
TAG	 	LSC IDENTIFYING INFORMATION)	+	TAG			DATE
		o stated, "I haven't been			and what systemic changes be made to ensure the defice		
	_	on my legs for a long			practice does not recur?Sta		
	timesince the s	troke."			inservicing was done on 6/2		
					and is ongoing on the use o	f the	
	Interview of Cer	tified Nurse Aide #1 on			stand-up lift and transfers.		
	6/24/11 at 2:20 p	o.m. indicated she			Transfers will be reviewed w in the facility SWAT meeting	•	
	answered Reside	ent G's call light to find he			the Therapy Director and Do		
	had raised the he	ead of his bed to a 90			attendance. Care plans and		
	degree angle and	d it had stuck there. The			assignment sheets will be		
	resident had an i	nvoluntary stool and			updated with any changes.F		
	needed incontine	ence care, but they			will the corrective actions be monitored to ensure the def		
		th his bed in that position.			practice does not recur, ie, v		
		I thought and thought and			quality assurance program v		
	_	im in the stand-up lift and		put into place and the completion date?The Therapy Director and			
	_	He agreed to itHe'd					
		tand-up for transfers to					
	1	eelchair. He could do it.			the weekly facility SWAT me and also on all new admissi	-	
		s and shoulders." She		Care plans and aide assignme			
		In't see a difference		sheets will be updated wi			
		himself on the stand-up			changes. Any continued cor		
	٠ -	•			will be addresses in the mor	•	
		Is during a regular transfer minutes it would take to			quality assurance meeting v written action plan. The plar		
					be monitored by the		
		involuntary stool. She			Administrator/DON/designe	e until	
	1	ad decided against using			resolution occurs.		
		oed in the room or other					
	1 ^	dicated, "He was moaning					
	_	couldn't hold on, but we					
		o it. We told him we					
		e and he kept saying he					
		anymore and then he just					
	let goHe could	have done it but he didn't					
	want toHe'd be	een doing just fine." She					
	indicated she and	d CNA #2 had not					
	conferred with the	he charge nurse before					

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPI	
		155206	B. WIN	IG		06/24/2	2011
NAME OF	PROVIDER OR SUPPLIE	B.		STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					ORNADAY ROAD		
BROWN	SBURG HEALTH C	CARE CENTER		BROW	NSBURG, IN46112		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROP DEFICIENCY)	Æ RIATE	COMPLETION
TAG	†	R LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCT)		DATE
	_	ision. She indicated the					
		mation/assignment sheets					
	1	tand-up lift. She					
	1	ent G had not fallen, only					
	1 -	n the straps of the lift					
	leaning toward t	the bedside chair.					
	Tudou : 21 -	1. Dimerten CN					
		he Director of Nursing					
	1 '	p.m. indicated she was					
	now aware the r						
	1 -	rmation sheet which was					
		0/11 did indicate both					
	1 ^	nation: Resident G could					
	1	and to use the stand-up					
	1	She agreed this was					
	1	d had become aware of it					
		vent occurred. She had					
	1 ^	how unacceptable this					
		kept repeating" to her that					
	1	.he did it beforehe just					
		Review of the current					
	1	nment/information sheet					
		ndicated it did state he					
	1	veight, but it did not direct					
	staff as to how t	o transfer him.					
	l						
		e plan addressed the issue					
		ndicated with an					
	1	led 4/19/11 as "hoyer lift					
	transfer-use 2 pe	eople."					
	1	relates to complaint					
	number IN0009	91302.					

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

l		IXI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155206	(X2) MULTIPLE CC A. BUILDING B. WING	00 	COMP 06/24/2	LETED
NAME OF PROVIDER OR SUPPLIER BROWNSBURG HEALTH CARE CENTER			STREET A 1010 H	ADDRESS, CITY, STATE, ZIP COD ORNADAY ROAD NSBURG, IN46112	Е	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APP DEFICIENCY)	JLD BE	(X5) COMPLETION DATE
	3.1-45(a)(1)					